

MEDICAL EVALUATION

Check all that apply: EH/AH ALP Initial RUG Category Change 12 Month

This form may be used to verify that an Individual's health/safety needs can appropriately be met in an adult home, enriched housing program or residence for adults. It may also be used to verify that an applicant/resident of an Assisted Living Program (ALP) is medically eligible to reside in a nursing facility but does not require continual nursing or skilled care and the individual's needs can be met in an ALP.

Name: _____			
Facility Name: _____			
Address: _____			
Sex M [<input type="checkbox"/>] F [<input type="checkbox"/>]	Date of Birth	Weight	B/P

Primary Diagnosis: _____

Secondary Diagnosis: _____

Significant medical history and current conditions: _____

CHHA reminder: assist with oxygen <input type="checkbox"/> Orders/Hours on: NA Glucometer Testing <input type="checkbox"/> Freq/Perimeters: NA	Continance: Bladder: <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel: <input type="checkbox"/> Yes <input type="checkbox"/> No
Needs assistance with self-administration of meds? <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies: _____	Diet: <input type="checkbox"/> NCS <input type="checkbox"/> NAS <input type="checkbox"/> Regular Supplement _____

List all current medications (prescription and OTC), including dosage, type, frequency, and method of administration, and note any special instructions: (attach additional sheet if necessary) Please specify reasons for prn /parameters, MD notification. Attach scripts for medications and DME.	
1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

DNR Continues Yes No PRI Order (q 6 mos/change in condition) Yes No

Is the Individual:

Free of communicable disease? Yes No. If no, describe _____

Able to transfer without assistance? Yes No. If no, describe _____

Ambulatory without assistance? Yes No. If no describe _____

Describe Activity Restrictions/Assistance Needed with ADL's (e.g. eating, transferring, toileting):

Eating/escorts _____ Toileting/hygiene _____

Personal care _____ Safety checks: Yes No _____ Frequency _____

Describe Current Treatment Plan (e.g. nursing, therapies, labs, etc.): **Supervision of all Medications by Adult Care**

Facility _____

SNV: ALP q6m & PRN Change in Condition. Assess & Evaluate plan of care appropriate to residents clinical needs. Supervise and evaluate performance of aide through _____ (site) ALP q6mo.

CHHA assistance for personal/escorts, AM/PM 24-hours 7 days a week per care plan.

Summary: Admit/continues to benefit from ALP support services.

MEDICATION EVALUATION (Page 2)

Name: _____

Activities Permitted

- 1 Complete bedrest
- 2 Bedrest BRP
- 3 Up as tolerated
- 4 Transfer Bed/Chair
- 5 Exercises Prescribed
- 6 Partial weight bearing
- 7 Independent at home

DME/Other Equipment

- A Crutches
- B Cane
- C O2 _____
- D Foley
- E Commode
- F Urinal
- G Attends

- H Shower Chair
- I TEDS/JOBST Stockings
- J Wheelchair
- K Walker
- L No Restrictions
- M Glucometer
- N Other (Specify)

Functional Limitations

- 1 Amputation
- 2 Bowel/Bladder
- 3 Contracture
- 4 Hearing

- 5 Paralysis
- 6 Endurance
- 7 Ambulation
- 8 Speech

- 9 Legally Blind
- 10 Dyspnea w/Min. Exertion
- 11 Other (Specify)

- Mental Status:***
- 1 Oriented
 - 2 Comatose
 - 3 Forgetful
 - 4 Depressed
 - 5 Disoriented
 - 6 Lethargic
 - 7 Agitated
 - 8 Other

- Prognosis:***
- 1 Poor
 - 2 Guarded
 - 3 Fair
 - 4 Good
 - 5 Excellent

Goals: Maintain optimal level ADL functioning in ALP. Safety optimized by supervised environment.

Rehab: Good potential related to health status.

Discharge: Remain in ALP until increase or decrease level of care defined _____

Is the individual's condition stable? Yes No. If no, describe: _____

Is a Mental Health Evaluation recommended? Yes No. (If yes. See attached form)

Date of Today's Examination: _____ Recommended Frequency of Medical Exams: _____
(minimum every 6 months for ALP recertification)

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens and that the individual is medically appropriate to be cared in an adult home, enriched housing program or an ALP.

Signature: _____ **Date:** _____
Physician (required)

Provider telephone number _____

Policy Procedures Reviewed/Revised	
Date: 5/7/02	By:
Date:	By:
Date:	By:

MENTAL HEALTH EVALUATION

“Each mental health evaluation shall be a written and signed report from a psychiatrist, physician, nurse, psychologist or social worker who has experience in the assessment and treatment of mental illness.”

Name: _____

Examination Date: _____

1. Is the individual mentally suitable for residence in an Adult Care Facility?

____ Yes ____ No _____

2. Does the individual require placement in a mental health care facility?

____ Yes ____ No _____

3. Significant mental health history and current conditions:
(Please include suggestions and follow-up treatment plan).

4. Prescribed Medication:

I have conducted a face-to-face examination of this individual.

Signature

Date